

THIRD PARTY RECOVERY ACCIDENT INFORMATION REPORT

RECIPIENT'S NAME:	
DATE OF BIRTH:	
RECIPIENT'S MEDICAID ID# (IF KNOWN):	
RECIPIENT'S SOCIAL SECURITY NUMBER:	
COUNTY OF RESIDENCE:	
DATE OF ACCIDENT:	
INJURY SUSTAINED:	
LAST DATE OF TREATMENT:	
TYPE OF ACCIDENT:	<input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Medical Malpractice <input type="checkbox"/> Product Liability <input type="checkbox"/> Other
INSURED RESPONSIBLE FOR ACCIDENT:	
POLICY/CLAIM NO.:	
INSURANCE COMPANY OR AGENT:	
MAILING ADDRESS:	
PHONE NUMBER:	
FAX NUMBER:	
RECIPIENT'S ATTORNEY:	
MAILING ADDRESS:	
PHONE NUMBER:	
FAX NUMBER:	
COMMENTS:	
SUBMITTED BY:	TITLE:
DATE:	TELEPHONE NO.:

Mail Original To:

**North Carolina Department of Health and Human Services
 Division of Medical Assistance/Third Party Recovery Section
 2508 Mail Service Center
 Raleigh, NC 27699-2508
 Telephone No.: (919) 647-8100**